COUNTY OF ERIE, NEW YORK

The Erie County Department of Mental Health

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August, 2012

Description of the Erie County Department of Mental Health's programs, services and responsibilities

Contents

Overview

The Erie County Department of Mental Health oversees mental disability services for over 48,000 Erie County residents each month through contracts with 46 community based agencies, including the Erie County Medical Center and Erie County Departments of Senior Services, Social Services and Youth Services. The Department of Mental Health is administratively responsible for planning, directing, coordinating, and monitoring programs of prevention, treatment and rehabilitation involving mental health, mental retardation-developmental disabilities, problem gambling and, alcohol and substance abuse services. A wide range of services and programs are provided within the City of Buffalo and fifteen municipalities throughout Erie County.

The Department of Mental Health is comprised of two Divisions; the Division of Program Administration and the Division of Forensic Mental Health Services. The Department plans, administers and coordinates a countywide integrated system of comprehensive community based mental health, mental retardation, alcohol and substance abuse programs which provide adequate levels of quality service to individuals in need of care and treatment, or at risk of institutionalization. Services are provided on a contract basis by community based agencies, other County departments or directly by the Department's Forensic Mental Health Division.

The Department receives state aid reimbursement for a percentage of the direct cost of programs and administration. It also is the recipient of a number of State and Federal grants that are used to supplement the operating budget and provide mental health, alcoholism and substance abuse programs that, otherwise, could not be provided at the same level.

Mission, Vision and Values

Mission

> The Erie County Department of Mental Health provides administrative leadership and ensures the coordination of a community based behavioral health system that is accessible, comprehensive, person centered and recovery focused.

Vision

> The Erie County Department of Mental Health will empower stakeholders to access behavioral health services that promote hope, recovery and improved quality of life.

Values

The Department will be guided by the following key values:

- Promoting choice, hope and independence

- Fostering practices based on research
- Providing training and educational opportunities
- Advocating for parity and inclusion
- Ensuring collaborative partnerships with diverse stakeholders
- Delivering cultural competence

Program Administration

The Division of Program Administration determines needs, develops annual and long range plans for the delivery of mental health services, and monitors and evaluates the implementation and delivery of planned services. The Division administers, coordinates and integrates services provided by behavioral health system agencies, ensures coordinated treatment for multiple disabled individuals and the appropriate transfer of clients between levels of care and institutions. These coordinative functions have been significantly upgraded with the implementation of the Assisted Outpatient Treatment Program. Through this Program, the Division oversees screening and assessment, Treatment Plan development, coordination of a centralized intake function for the assignment of Care Coordination, preparation of petitions and court testimony, and monitoring provision of services, compliance with treatment plans and the achievement of service outcomes.

Mental Health Services, including inpatient care, clinic treatment, continuing day treatment, residential services, case management and a continuum of community support and rehabilitation services are provided to approximately 33,400 persons each month. Services are delivered by 28 community based agencies under contract with the Department of Mental Health. These agencies include the Erie County Medical Center and the Departments of Senior Services and Youth Services. Services are provided by a decentralized network of service providers within urban, suburban and rural areas throughout the county to assure client access to needed services.

Developmental Disability Services, including work activity day programs and day training programs are provided to approximately 2,050 persons per month. These services are delivered by 3 community based contract agencies. Within day training programs, available services include service coordination to non-Medicaid eligible individuals, senior day activities, independent living skills training, recreation opportunities, legal services and supports for self-advocacy.

Alcohol and Alcohol Abuse Services, including inpatient detoxification, clinic, day rehabilitation and community residential programs, are provided to approximately 11,160 persons per month through 8 community based contract agencies. Community agencies also provide alcohol abuse prevention education information and referral programs in local schools and on behalf of community groups.

Substance Abuse Services, including inpatient detoxification services, outpatient drug free programs, and methadone maintenance programs, are provided to approximately 3,500 persons annually. These

services are provided by 9 community based agencies. In addition, school and community groups receive drug abuse prevention information and referral programs through contract agencies.

The Division of Program Administration receives state aid reimbursement for a percentage of the direct costs of programs and services provided by community based and other agencies under contract with the Department. Additionally, it receives state aid reimbursement for a percentage of the division's program administration costs.

The Division also receives a number of State and Federal grants for mental health, alcoholism and substance abuse programs which are used to supplement the operating budget and provide services that could not otherwise be provided at the same level. Finally, through interfund agreements with the Department of Social Services, the Division contracts for prevention, treatment, and family support services to address the mental disability needs of families eligible under Temporary Aid to Needy Families (TANF).

DIVISION OF PROGRAM ADMINISTRATION OBJECTIVES:

- To develop annual plans for mental health, mental retardation/developmental disabilities, and alcohol and substance abuse services that identify service needs and program development areas consistent with available resources.
- To prepare and submit countywide and disability specific budget documents necessary to meet state and local funding requirements, and effectively implement approved budgets.
- To negotiate and execute contracts and service agreements with all contract agencies.
- To develop and implement policies and procedures that guide voluntary not-for-profit agencies under County contract. Focus is on implementation of clinical services and management practices that are consistent with both applicable guidelines and regulations for delivery of state funded programs and acceptable business practices.
- To regularly monitor contract agencies to assure attainment of contract expectations for service levels, target populations, program development, service quality, professional standards and effective agency management.
- To provide effective administration and monitoring of all State and Federal grant programs to assure effective coordination and integration of grant supported services and programs with the Department's overall service plan.
- To ensure coordination among service providers and assure the non-duplication of services.
- To provide technical assistance, information and advice to contractual agencies as needed to resolve program and management issues and to promote best practices.
- To collect and analyze data and provide evaluations of programs and assessments of service operations and impact.
- Operate Single Points of Access for Children and Adults consistent with providing the right service at the right time for the right length of time and the right outcome.

Intensive Services for Children and Adults

The Department operates a Single Point of Access (SPOA) for Children's Intensive Services and a SPOA for Adult Intensive Services. The Children's (SPOA) is a process designed to identify, screen and assign Care Coordination and Wraparound Services to eligible high need/high risk children and youth with a serious emotional disturbance (SED) and/or behavioral disorder and their families. The Adult SPOA provides timely access to intensive community based Care Coordination, Assertive Community Treatment (ACT), Assisted Outpatient Treatment (AOT) and/or Housing services and supports for adults with severe mental illness. Care Coordination, ACT, AOT and/or Housing services are intended for individuals who are at high risk of further system penetration, who are unable to maintain community based linkages and important supports.

In addition to its primary administrative function, the Department of Mental Health, through its Forensic Mental Health Service, performs referrals, evaluations, and screenings on behalf of Erie County Family Court and Criminal Court Systems. In addition, Forensic Mental Health Service provides follow up treatment for mentally ill individuals under the jurisdiction of the Courts, Probation Department, Correctional Facility and Holding Center. The telephone number for this Service is 858-8095.

The Department also administers Federal and State Grants promoting Service Enhancements for Mentally Ill Children, Drug Free Outpatient Services, Juvenile Delinquent Diversion Services, and McKinney Homeless Mentally Ill Supported Housing funded by the United States Department of Housing & Urban Development (HUD).

Division of Forensic Mental Health Services

The Division of Forensic Mental Health Services includes both an Adult Forensic Mental Health Clinic located at the Erie County Holding Center and the Erie County Correctional Facility, and a Family Court Clinic.

Adult Forensic Mental Health Services include psychiatric evaluation of individuals detained for trial or prior to sentencing, and the care and follow-up treatment of mentally ill individuals under the jurisdiction of the Courts, Probation Department, Correctional Facility and Holding Center.

The Family Court Clinic provides outpatient mental health services to children and adults who are under the jurisdiction of Family Court. These services include emergency assessment in court, linkage and referral, diagnostic evaluation and testing, and mental health consultation. The clinic provides recommendations to the referring judge or county department regarding court disposition or department resolution.

ADULT FORENSIC MENTAL HEALTH SERVICES OBJECTIVES:

- To provide psychiatric evaluations of individuals to determine competency, as ordered by the courts.
- To provide psychiatric treatment to inmates to enable their participation in court proceedings.
- To provide ongoing assessment of inmates on behalf of attorneys, probation and parole officers, and youth detention personnel.
- To provide ongoing psychiatric treatment or mental health services to inmates.
- To provide advocacy and linkage to community mental health services for persons on probation or parole.
- To conduct professional training programs on forensic mental health issues to criminal justice system and law enforcement personnel.

FAMILY COURT OBJECTIVES:

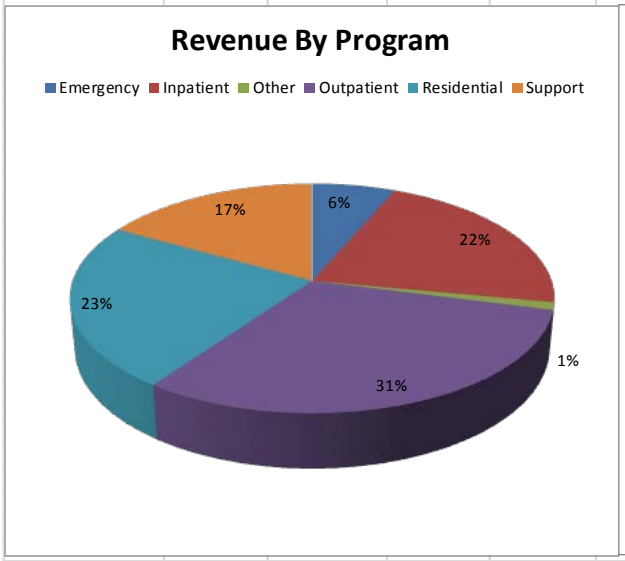
- To provide psychiatric evaluation and mental health assessment for children and adults as ordered by Family Court.
- To provide emergency psychiatric evaluations of children or adults as ordered by the Family Court under Section 251 of the Criminal Procedure Law.
- To refer persons to community based mental health agencies for follow-up services.

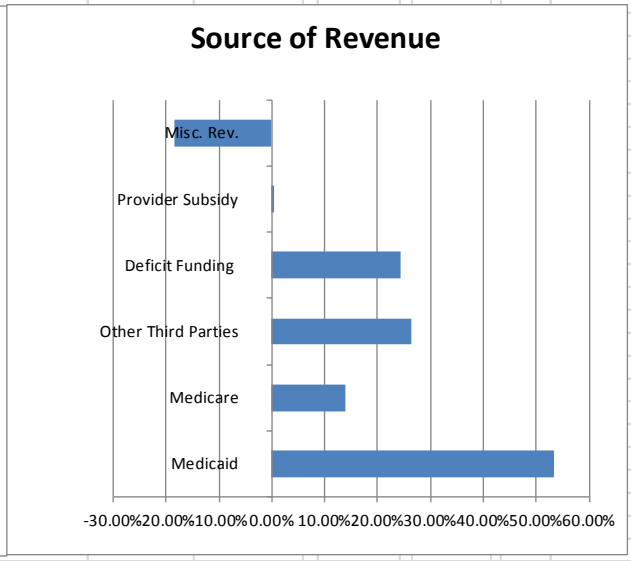
Consolidated Fiscal Report – Office of Mental Health

Erie County Mental Health System
2010 Consolidated Fiscal Year End Results
By Category By Payor

Total Support = 138,678,810

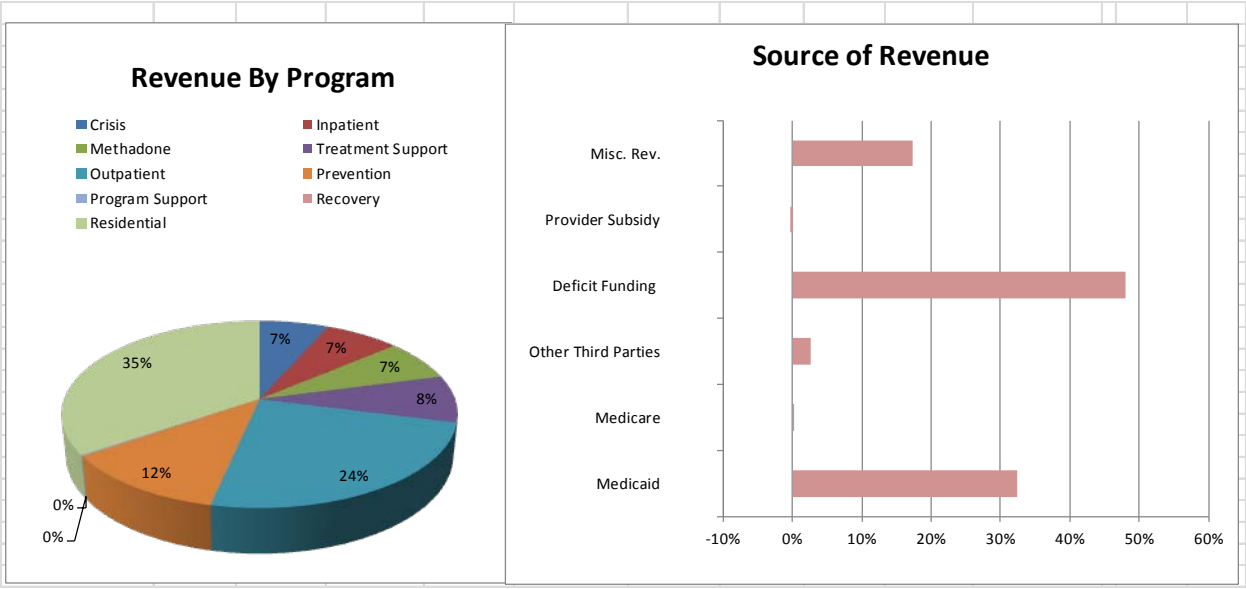
	Emergency	Inpatient	Other	Outpatient	Residential	Support	Total	Percent of Total
Medicaid	5,184,078	21,898,332	0	27,689,809	12,748,557	6,486,861	**74,007,637**	**53.37%**
Medicare	3,080,044	13,807,163	0	2,380,312	0	31,418	**19,298,937**	**13.92%**
Other Third Parties	13,072,187	16,702,356	0	6,796,957	0	67,053	**36,638,553**	**26.42%**
Deficit Funding	2,335,182	1,034,903	1,113,364	2,605,074	11,991,215	14,833,864	**33,913,602**	**24.45%**
Provider Subsidy	(2,402,066)	(481,845)	9,342	2,638,663	89,154	563,551	**416,799**	**0.30%**
Misc. Rev.	(12,349,024)	(23,062,233)	298,389	686,385	7,453,533	1,376,232	**(25,596,718)**	**-18.46%**
Total	**8,920,401**	**29,898,676**	**1,421,095**	**42,797,200**	**32,282,459**	**23,358,979**	**138,678,810**	**100.00%**
Percent of Total	**6.43%**	**21.56%**	**1.02%**	**30.86%**	**23.28%**	**16.84%**	**100.00%**	





Consolidated Fiscal Report – Office of Alcohol and Substance Abuse Services

Erie County Chemical Dependency Services 2010 Consolidated Fiscal Year End Results By Category By Payor											
					Total Support =	24,177,873					
	Crisis	Inpatient	Methadone	Treatment Support	Outpatient	Prevention	Program Support	Recovery	Residential	Total	Percent of Total
Medicaid	545,905	1,336,405	1,705,890	0	2,805,313	0	0	0	1,441,455	**7,834,968**	**32.41%**
Medicare	0	0	0	0	29,723	0	0	0	0	**29,723**	**0.12%**
Other Third Parties	4,025	3,920	3,966	0	533,834	0	0	0	73,302	**619,047**	**2.56%**
Deficit Funding	1,042,661	0	0	1,924,866	1,521,762	2,519,970	0	0	4,582,554	**11,591,813**	**47.94%**
Provider Subsidy	0	0	(79,215)	28,945	114,949	0	0	0	(131,520)	**(66,841)**	**-0.28%**
Misc. Rev.	1,704	398,047	81,314	13,817	890,548	372,061	50,000	0	2,361,672	**4,169,163**	**17.24%**
Total	**1,594,295**	**1,738,372**	**1,711,955**	**1,967,628**	**5,896,129**	**2,892,031**	**50,000**	**0**	**8,327,463**	**24,177,873**	**100%**
Percent of Total	**6.59%**	**7.19%**	**7.08%**	**8.14%**	**24.39%**	**11.96%**	**0.21%**	**0.00%**	**34.44%**	**100.00%**	

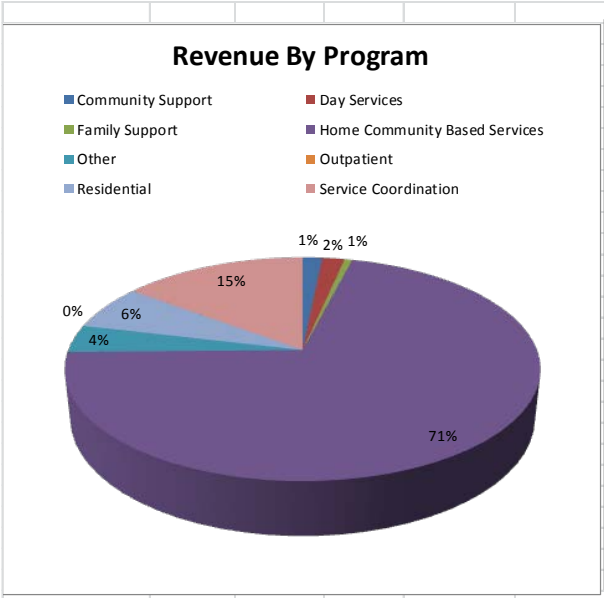


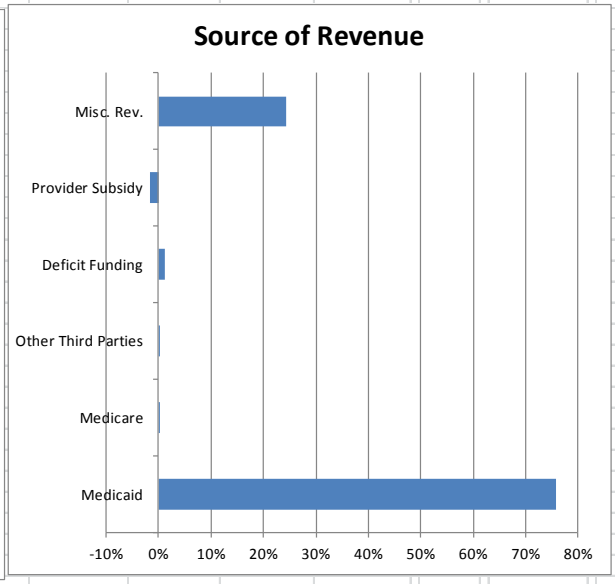
Consolidated Fiscal Report – Office for People with Developmental Disabilities

Erie County Developmental Disabilities
2010 Consolidated Fiscal Year End Results
By Category By Payor

Total Support = 279,911,679

	Community Support	Day Services	Family Support	Home Community Based Services	Other	Outpatient	Residential	Service Coordination	Total	Percent of Total
Medicaid	0	0	29,255	175,586,562	290,278	0	17,014,637	19,078,920	**211,999,652**	**76%**
Medicare	0	0	0	0	0	0	0	305,570	**305,570**	**0%**
Other Third Parties	0	0	0	16,384	0	0	408,248	246,015	**670,647**	**0%**
Deficit Funding	81,551	1,095,321	1,583,605	14,618	620,797	0	0	32,624	**3,428,516**	**1%**
Provider Subsidy	4,328,050	900,912	87,258	(15,772,433)	10,273,040	0	249,429	(4,611,712)	**(4,545,456)**	**-2%**
Misc. Rev.	553	3,029,592	1,490	38,043,869	44,164	0	578,531	26,354,551	**68,052,750**	**24%**
Total	**4,410,154**	**5,025,825**	**1,701,608**	**197,889,000**	**11,228,279**	**0**	**18,250,845**	**41,405,968**	**279,911,679**	**100%**
Percent of Total	**2%**	**2%**	**1%**	**71%**	**4%**	**0%**	**7%**	**15%**	**100%**	





2013 Local Services Plan Executive Summary

The changes in the environment related to New York State's movement towards managed care environments are prompting action by Erie County to adapt its Systems of Services (SOS). The vision for the Erie County System of Services is that providers will be working together in an organized system of care, where optimally effective services are available in a timely manner to the emerging populations. In this system of services, providers are focused on working interdependently with individuals, families and natural supports to reduce imminent risk or bend the trajectory of risk and to ease transitions to care and support by removing barriers to care that will keep people in the community rather than focusing on keeping people out of the institutional care. Services will be provided using a person centered approach to care that provides access to the right service at the right time for the right length of time for the right outcome. Throughout the reform initiative if there is an opportunity to do a short-term pilot that is data informed Erie County will employ this approach to further healthcare reform efforts.

The impetus behind healthcare reform in Erie County includes a belief that changes are occurring rapidly and that there is an urgent need to manage healthcare reform at the local level. There is a short-term opportunity for Erie County, providers, consumers and stakeholders to take advantage of the reform opportunity offered by Regional Behavioral Health Organization and Health Home initiatives. Erie County intends to demonstrate the value of locally driven systems of care that align with New York State's healthcare reform initiatives in the next 6-8 months, before the next round of Requests For Proposals are released for managed behavioral health care. To address this locally Erie County will focus local health reform efforts on:

- Priority Populations: Priority participant lists will be developed to reflect those people who are at greatest risk of needing deep end services
- Efficacy of Practice: The efficacy of clinical practice of the Erie County will be attained through changes in practice and fidelity to evidence based practices.
- Access to services: The capacity of the system will be managed to improve access for the priority population to the right service at the right time for the right reason for the right length of stay
- Metrics that Matter: Data informed practice and data informed structures will be the underpinning of this change initiative to identify high risk/high need populations, track clinical outcomes, and measure the overall performance of the system of services

Erie County is committed to a healthcare reform "risk reduction" approach. Historically, rehabilitation & recovery have meant long-term support. Now providers will assist consumers to receive ongoing treatment & support through removal of barriers to community-based services both inside and outside of the healthcare system.

Under Healthcare Reform the expectation of the services available and provided to individuals will change for consumers, providers, and regulators. In Erie County changes needed for providers, consumers and county staff include the following:

- Consumers - What expectations do clients have of the service they receive? Under reform consumers will have the information needed to make informed choices to move toward greater self-management, and will be prepared for discharge and transition.
- Providers - What expectations do providers have of the services they will deliver? Provider focus on inpatient diversion and long-term support will need to shift to their practice to assist consumers by removing barriers to services that will support them in their recovery. Providers will need to assist consumers on linkages and transitions to services and community supports. Recognizing that services need to be individualized, stability and treatment are essential to recovery with the right blending of supports both natural and formal so that people get the right level of support when needed.

How will Erie County measure Systems Change?

- Measures of engagement & timely access
- Measures of fidelity to practice i.e. identify how the interventions are done and measure the interventions
- Measures of outcomes
- Measures of community impact e.g. emergency room presentations, inpatient cost, homelessness and arrests

Erie County recognizes that the scope of this reform initiative will have significant impact on consumers, providers, and county operations as the transformation occurs in the context of uncertainty, rapid change and state managed care initiatives. The impact will prompt changes in clinical and business practices, the experience that consumers have with providers, and the shape of services delivered to consumers.

- Providers may choose to adapt to the Erie County Healthcare Reform incrementally or with a more robust system change approach. Providers who can achieve a valued outcome within a normative timeframe, will likely move ahead of their competition and gain market share. Consumers will experience an approach in which the provider will focus on short-term interventions & supports that are person centered and recovery oriented. As a result consumers may experience a sense of loss of services and/or long-term relationships due to their prior involvement with and dependency on the formal provider network and long-term support models.
- Providers will need to work with consumers to manage their expectations relative to lengths of stay and relationship with the provider system, so that the consumer is given hope for recovery through improved self-management skills.
- Erie County will work with providers and consumers to promote self-sufficiency through role modeling of peers, support during critical transitions, and with on-site services relative to work and independent housing, and through transitions.

Critical Time Intervention (CTI) will be a critical tool to support this approach. CTI is an empirically supported, time limited case management model designed to enhance continuity of support for people with mental illness following discharge from hospitals, shelters, prisons and other institutions. CTI works in two main ways: by providing emotional and practical support during transitions and by strengthening

the individual's long-term ties to services, family, and friends. Ideally, post-discharge assistance is delivered by workers who have established relationships with clients during their institutional stay.

Erie County made significant strides in changing the Erie County Children's System of Care by employing training, communication, inclusive planning and culture change in service delivery that included consumers, families and providers. The transformation of the children's system has been significant, resulting in improved community service options, decreased use of residential treatment, measurable clinical outcomes and consumer satisfaction. These efforts and outcomes have been recognized by CMS and the New York State Office of Mental Health. Therefore Erie County is committed to using similar approaches in communication and culture change in service delivery in this Healthcare Reform initiative, and will include peer training of providers and the development of a learning community.

Our immediate first priority is to prepare for the conversion of Medicaid fee for service to Medicaid Managed Care. The new or evolving Medicaid services should be comprehensive, integrated and capitated. This will involve changes for individual consumers, family members, service providers of behavioral and primary health care. New reimbursement structures may reduce or eliminate Medicaid add-ons.

Our second priority is to assure that individuals who are at risk of deeper-end service penetration that are not enrolled in a managed system. Our local responsibility is to assure access to timely, adequate, affordable, appropriate, and quality outcome driven services. This sub-population includes uninsured, under-insured, and at least initially, dual eligible individuals.

Our third priority is to reduce the number of potentially preventable admissions to hospitals for individuals diagnosed with behavioral health disorders.

Key Initiatives – Health Care Reform

The changes in the environment related to New York State's healthcare reform are prompting action by Erie County to adapt its adult system of care. The vision for the Erie County Adult System of Care (SOC) is that providers will be working together in an organized system of care, where optimally effective services are available in a timely manner to the emerging populations. In this system of care providers are focused on working interdependently to reduce imminent risk or bend the trajectory of risk and to ease transitions to care and support by removing barriers to care that will keep people in the community (CTI) rather than focusing on keeping people out of the hospital. Services will be provided using a person centered approach to care that provides access to the right service at the right time for the right length of time. Throughout the reform initiative if there is an opportunity to do a short-term pilot that is data informed Erie County will employ this approach to further healthcare reform efforts. In

addition, the vision for Healthcare Reform in Erie County anticipates shifts in business and clinical practice that reflect the following county roles:

- Use of Data Analytics: Erie County will work on the development of a risk-based, predictive model to explain trajectory of deep-end system penetration. Primary focus is to make the results translatable to professionals so the results can impact administrative, supervisory and direct practices. This model will be incorporated into the daily decision making processes of professionals in the adult system of care.
- Business Practices: Erie County will work on the development of performance measures that are meaningful, and are used to support critical metrics and activities
- Quality Improvement and Accountability: Erie County will work to develop and identify critical metrics, outcomes and system needs based on evidence based practices, utilization management data and other critical data to drive decision-making and contract performance standards
- SPOA: Erie County will launch a paradigm shift for the placement, service methodology and outcomes associated with housing and care coordination will be used such that the assignment of individual consumers to appropriate housing will utilize a risk based algorithm and interventions will support individual transition to fuller community participation and decreased dependence on behavioral health housing and care coordination.
- Utilization Management: Erie County and Erie County Providers will drive clinical and service decisions based on the 5 Rights of UM (right person, right service, right time, right length of time, achieving right outcome) and these 5 Rights will be incorporated into SPOA (care coordination and housing) and Care Coordination Agency practice.
- CTI as a Philosophy of Care: Critical Time Intervention (CTI) is the best practice model that will drive the paradigm shift desired under the Erie County Healthcare reform. The Erie County Adult System of Care and those stakeholders involved in all phases of service delivery, will view its role and monitor its practice based on client linkages with community supports

The details of these functional vision statements will be guided by a process of stakeholder involvement.

Themes: The impetus behind healthcare reform in Erie County includes a belief that changes are occurring rapidly and that there is an urgent need to manage healthcare reform at the local level. There is a short-term opportunity for Erie County, providers, consumers and stakeholders to take advantage of the reform opportunity offered by RBHO and Health Home initiatives. Erie County intends to demonstrate the value of locally driven systems of care that align with the state healthcare reform initiative in the next 6-8 months before the next round of RFPs is released for managed behavioral health care. To address this locally Erie County will focus local health reform efforts on:

- Priority Populations: Priority participant lists will be developed to reflect those people who are at greatest risk of needing deep end services
- Efficacy of Practice: The efficacy of clinical practice of the Erie County MHSA system will be attained through changes in clinical practice.

- Access to services: The capacity of the system will be managed to improve access for the priority population to the right service at the right time for the right reason for the right length of stay.
- Metrics that Matter: Data informed practice and data informed structures will be the underpinning of this change initiative to identify high risk/high need populations, track clinical outcomes, and measure the overall performance of the adult system of care.

Key Initiative – Critical Time Intervention

TIME-LIMITED CARE COORDINATION TO PROMOTE LASTING IMPACTS

www.criticaltime.org

Critical Time Intervention (CTI) is an empirically supported, time-limited case management model designed to enhance continuity of support for people with mental illness following discharge from hospitals, shelters, prisons and other institutions. This transitional period is one in which people often have difficulty re-establishing themselves in stable housing with access to needed supports. CTI works in two main ways: by providing emotional and practical support during the critical time of transition and by strengthening the individual's long-term ties to services, family, and friends. Ideally, post- discharge assistance is delivered by workers who have established relationships with clients during their institutional stay. CTI was originally developed at Columbia University and New York State Psychiatric Institute with significant support from the National Institute of Mental Health and the New York State Office of Mental Health. The model is now being widely applied and tested in the US, Europe and South America. It is listed in the **National Registry of Evidence-Based Programs and Practices** and was recently endorsed by the **Coalition for Evidence-Based Policy**.

A model borne from experience

CTI grew out of experience working in large shelters in New York City during the early 1990s. The shelters housed large numbers of chronically homeless men, many of whom had severe mental illness and substance abuse problems. Over the course of several years, on-site mental health teams at these shelters developed comprehensive treatment programs delivering outreach and case finding, psychiatric medication, rehabilitation groups, entitlement counseling, family work and case management. After a significant period of shelter-based treatment, the mental health teams were able to refer many of their clients into housing. We found, however, that many men placed into housing became homeless again soon after discharge from the shelter. Despite having solid discharge plans and access to housing, the men still did not have the type of assistance they needed to overcome the natural discontinuity in support they experienced during their transition.

A transition can be a critical time

One reason that transitional periods are especially challenging is that clients are typically expected to navigate a complex and fragmented system of care. In addition, clients in transition often lose personal relationships they may have developed with key individuals—both service providers and other clients--during their institutional stay. These relationships may have provided important sources of support that end abruptly following their move. The transition period can also be a difficult time in the relationship between the client and his or her family and social network who may not be aware of how best to provide needed support. This suggested the need for efforts to improve continuity of care during the "critical time" of transition to community living. We hoped that

an effective time-limited intervention provided during this key period might have lasting benefits by helping to strengthen a network of community support that would last beyond the period of the intervention itself.

How is CTI similar to assertive community treatment and intensive case management?
CTI shares with long-term assertive community treatment and intensive case management models a focus on integrating clients in the community through development of independent living skills and by building effective support networks. Like ACT and ICM, its approach also relies heavily on effective outreach and engagement by staff working in the community rather than in the office. Unlike ACT and ICM, CTI is time-limited, lasting for nine months after institutional discharge or placement into housing. Rather than providing ongoing assistance, CTI's emphasis is on mobilizing and strengthening client supports during the critical period of transition with the goal of ensuring that these supports remain in place afterwards. CTI is also highly focused, aiming primarily to help clients avoid homelessness.

The Critical Time Intervention Model

CTI is carried out in **three distinct phases** as described below.

Phase	Transition	Try-Out	Transfer of Care
Purpose	Provide specialized support & implement transition plan	Facilitate and test client's problem-solving skills	Terminate CTI services with support network safely in place
Activities	CTI worker makes home visits Accompanies clients to community providers Meets with caregivers Substitutes for caregivers when necessary Gives support and advice to client and caregivers Mediates	CTI worker observes operation of support network Helps to modify network as necessary	CTI worker reaffirms roles of support network members Develops and begins to set in motion plan for long-term goals (e.g. employment, education, family reunification). Holds party/meeting to symbolize transfer of care

Phase One: Transition to the Community focuses on providing intensive support and assessing the resources that exist for the transition of care to community providers. Ideally, the CTI worker has already begun to engage the client in a working relationship before he or she moves into the

community. This is important because the worker will build on this relationship to effectively support the client following discharge. During the first few weeks following this move, the CTI worker maintains a high level of contact with the client, both through regular telephone calls and home visits. Clients
are accompanied to appointments with selected community providers, such as mental health and medical clinics. The CTI worker "introduces" the client to his or her new providers in order to facilitate the development of a durable tie and encourages them to negotiate compromises when problems arise. The CTI worker also meets with key figures in the client's residence. They discuss potential housing crises and try to identify ways to avoid them or possible coping strategies and resources, should a crisis occur. The CTI worker offers support to these persons while making it clear that he or she is prepared, when necessary, to mediate a compromise between them and the client. He or she brings together clients, family members and service providers to enhance communication and to detail proposed arrangements to ensure medication adherence, money management, or control of substance abuse. The CTI worker generally makes detailed arrangements in only the handful of areas that are seen as most critical for the community survival of that individual; it is important not to be overly ambitious.

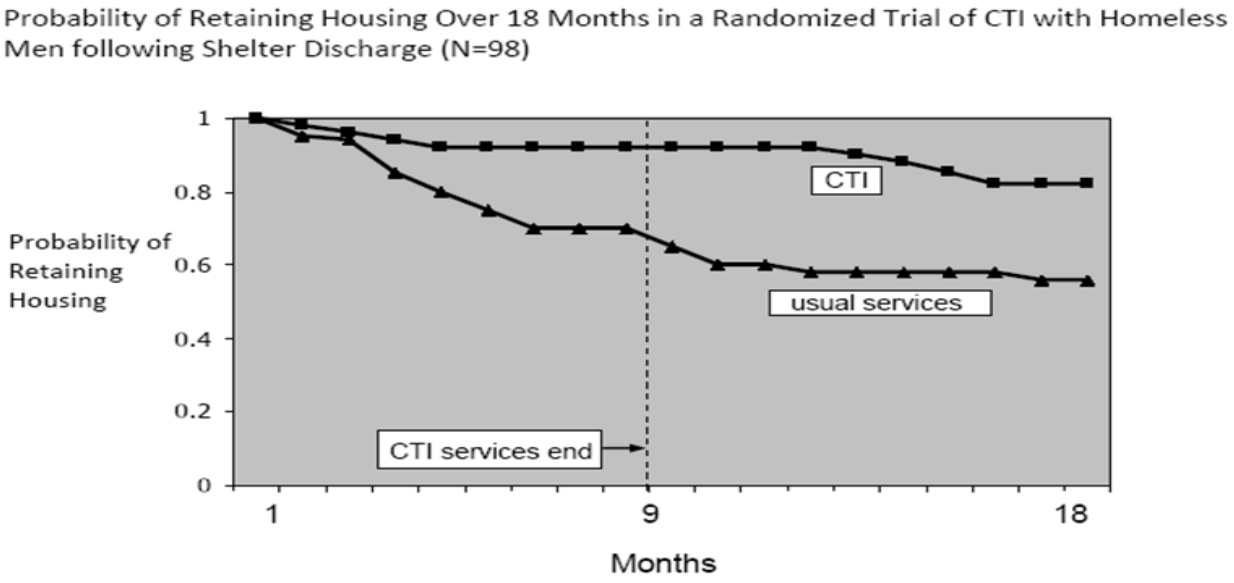
Phase Two: Tryout is devoted to testing and adjusting the systems of support that were developed in phase one. By now, community providers will have assumed primary responsibility for the provision of support and services, and the CTI worker can focus on assessing whether the support system is functioning as planned. During this phase, the worker encourages the client and his or her supporters to handle problems on their own. The worker meets with the client less frequently, but maintains regular contact in order to observe how the plan is working and be ready to intervene when a crisis arises. In many cases, modification of the support system is required. Such "system adjustment" may be accomplished via a case conference or less formal meetings between the client and those involved in the support system. The CTI worker acts as a primary resource for all parties and assists them in creating a framework for resolving potential conflicts. For some clients, this period requires a renegotiation of treatment plans and a more active role for the CTI worker in implementing these plans.

Phase Three:* T*ransfer of Care focuses on completing the transfer of responsibility to community resources that will provide long-term support to the client. One way that CTI differs from services typically available to clients during transitional periods is that the transfer of care process is not abrupt; instead, it represents merely the endpoint of work occurring over the full nine months. Throughout the intervention, the CTI worker has gradually reduced his or her role in delivering direct services to the client. The worker's main function in this phase is to ensure that the most significant members of the support system meet together and, along with the client, reach a consensus about the components of the ongoing system of support. Ideally, this occurs at least one month before the end of the intervention. This gradual process ensures that the termination of CTI is not seen by the client and the members of his or her support system as a sudden, potentially traumatic, loss.

Evidence for Effectiveness

CTI has been evaluated in several carefully designed studies. The first test of the model was a randomized trial1 that assessed the effectiveness of nine months of CTI in preventing homelessness among 96 homeless men with severe mental illness being placed into community housing

Increased Likelihood of Remaining Housed in Men with Severe Mental Illness



from a large municipal shelter in New York City. In this study, CTI led to a significant reduction in post-discharge homelessness over 18 months. As shown, the effect lasted beyond the end of the nine-month period of active intervention, consistent with the idea that the intervention successfully enhanced community supports. An economic analysis2 found that the CTI group and the usual services group incurred almost identical average costs for acute care services, outpatient services, housing and shelter services, criminal justice services, and transfer income over the follow- up period. Since these costs were associated with a significantly reduced homelessness in the CTI group, we concluded that the intervention was cost-effective in comparison with usual care.

A six-month version of the model was implemented at eight Department of Veterans' Affairs medical centers throughout the US. In a quasi-experimental study, 278 homeless persons with severe mental illness were recruited and followed for one-year after discharge from inpatient psychiatric treatment, receiving standard case management services in the community. Following this, case managers were trained in the CTI model and a second group of 206 subjects were recruited and offered CTI. Controlling for baseline differences between cohorts, investigators found that the CTI cohort had on average 19% more days housed than did the first cohort over the one-year follow-up period[3]. Another recently completed NIMH-funded trial[4] assessed the outcomes of 150 men and women with severe mental illness following discharge from state psychiatric hospitals in New York City. Using random assignment, half were offered CTI and half received standard discharge planning and follow-up care. Both groups were followed for 18 months. Subjects assigned to CTI were, on average, five times less likely to be homeless at the end of the study compared with subjects

assigned to the usual services group. Furthermore, subjects assigned to CTI were significantly less likely to be re-hospitalized during the follow-up period than were those in the comparison group[5].

[1] Susser et al. (1997). Preventing recurrent homelessness among mentally ill men: a "critical time" intervention after discharge from a shelter. American Journal of Public Health, 87(2), 256-262.

[2] Jones, K. et al. (2003). Cost-effectiveness of critical time intervention to reduce homelessness among persons with mental illness.
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[3] Kasprow, W. J., & Rosenheck, R. A. (2007). Outcomes of critical time intervention case management of homeless veterans after psychiatric hospitalization. *Psychiatric Services, 58*(7), 929-935.

[4] Herman, DB, S. Conover, et al. (2011) Randomized trial of critical time intervention to prevent homelessness after hospital discharge. *Psychiatric Services* 62(7): 713-719.

[5] Tomita, A & Herman, DB. (in press) The impact of critical time intervention in reducing psychiatric re-hospitalization following hospital discharge. *Psychiatric Services*.

Key Initiative – Children's System of Care

County Department of Mental Health Family Voices Network (FVN) / Single Point of Accountability (SPOA) is a process designed to identify, screen and assign Care Coordination and Wraparound Services to eligible high need/high risk children and youth with a serious emotional disturbance (SED) and/or behavioral disorder and their families. The SPOA process targets children and youth at risk and/or with history of hospitalization or out-of-home placement, with multi-system involvement or needs, with substantial functional impairments and/or psychiatric symptoms, and an unsuccessful history of interventions. The primary goals of FVN/SPOA include maintaining high risk/high need children in the community with their families, reducing out-of-home placements, facilitating the earlier return of children and youth already placed out-of-home, increasing access to community based services, utilizing an individualized care model with a strength-based approach and assuring active parent involvement at all levels of FVN/SPOA.

Erie County has developed one front door for home based community services for all children and families served by the Departments of Social Services, Mental Health and PINS/PINS Diversion from Juvenile Justice. Within this one door, staff from all three departments are co-located and work cooperatively and collaboratively to meet the needs of the children seeking services from the county. There are multiple ways that the needs of cross-system children and youth are being identified and addressed within this one door:

- Family Voices Network (FVN) / Children's SPOA conducts an intake meeting where system partners are involved along with the parents of the child/youth seeking services, then assigns care coordinators to the youth and families who then facilitate Child and Family Team (CFT) meetings for each identified cross-system youth. The CFT meetings occur every 30 days for ongoing individualized treatment planning. (Note that referrals come from this front door and across the community as well.);
- Family Services Team (FST) that consists of DSS, Probation and Mental Health staff that intake preventive services, voluntary placement requests and PINS Diversion matters. The overall goals are to meet family service needs, sustain youth in the community with their families and reduce inappropriate penetration into the Juvenile Justice System;
- Safety Net for Youth is the county's former Hard to Place/Serve Committee under the Coordinating Council on Children and Families those monthly reviews challenging cases. The multi-system members of the committee review case specifics and brainstorm potential solutions to the service need not being met; and,
- Juvenile Delinquency Services Team (JDST) has active participation of Family Court, DSS, Mental Health and Probation. The overall goals are to meet service/intervention needs of youth and families and reduce further penetration into the Juvenile Justice System yet maintain balance with community safety.

Family Voices Network of Erie County is a system of care for children/youth experiencing serious emotional, behavioral and/or social challenges. The mission is to provide comprehensive, coordinated, individualized, culturally competent and cost effective community based services that support the children/youth and their families in order to maintain them in their home and community. Care Coordination services are planned and delivered with a family driven, strength-based focus using the wraparound process which creates collaboration between the children/youth, their families and a team they select.

Target Population:

- Children and youth ages 5-17 years old
- Parent, caregiver or legal guardian must reside in Erie County
- Child/Youth experiencing serious emotional, behavioral and/or social challenges
- Child/Youth at significant risk of hospitalization or placement out of their home or community, or
- Child/Youth currently in placement out of home or hospitalized and requires community based services/supports to successfully return home

Referral Process:

1. Service provider and/or parent identifies that a child/youth meets the target population for Family Voices Network (FVN).
2. Service provider and parent/guardian complete FVN application and permission for disclosure form (consent form). Service/treatment summary is included that identifies risk of placement/hospitalization as well as part/current interventions to address those risk factors. If available, the DSM-IV 5Axis Diagnosis and the Child and Adolescent Functional Assessment Scale (CAFAS) score (by domain) must be included.
3. County FVN staff review materials for completeness and schedule Intake meeting as soon as possible. Referral source/service provider and parent/guardian/youth are expected to attend the Intake meeting.
4. When a family is approved for FVN Care Coordination, the parent/guardian and youth (if age appropriate) are given information to attend the required Child and Family Team (CFT) Orientation at Families CAN (Erie County's lead Family Support agency).
5. When a family is not approved for FVN, other services and/or supports are recommended by the Intake Committee to meet needs identified in the referral as well as by the family at the Intake meeting.

Performance Management

The Department has taken a leadership role in Quality Improvement. We continue to work with Agencies and Programs to promote active integration of data collection, monitoring & evaluation with management strategies and interventions in order to maximize service system performance and consumer valued performance measures.

The Erie County Department of Mental Health uses the Performance and Contract Management System (PCMS) for contracting purposes. This web based management application enables all parties to have access to pertinent contract information including but not limited to agency administrative, financial and performance deliverables, and the status of all deliverables. For example, the system supports documentation of service descriptions, target populations and other necessary information to describe the services provided under contract. In addition, the system supports tracking standardized program outcomes across programs and agencies.

In 2012, the Department incorporated program performance measures that are consistent with the emerging Managed Care /Capitated environment. These include more closely tracking length of stay, and monitoring inpatient medical admissions. The Department continues to focus on employment, and views working as a key indicator of recovery.

The Department uses data from a variety of available databases, including PCMS, PSYCKES, and Medicaid claims, for planning purposes and to assess program performance.